Central Region EMS and Trauma Care System Plan
July 1, 2021 – June 30, 2023

Central Region EMS and Trauma Care Council

Table of Contents

Introduction

The Central Region is located in King County, Washington There are thirty-four (34) licensed EMS services in King County. Five (5) provide advanced life support (ALS) service using paramedics, twenty-five (25) provide basic life support (BLS) service using EMTs and four (4) provide a combination of BLS secondary response to 911 calls using EMTs and specialty care interfacility transport services using nurses. There are eighteen hospitals and three stand-alone emergency departments in Central Region. There is one level I trauma center, four level III trauma centers, three level IV trauma centers and two level V trauma centers. Categorized Cardiac and Stroke Centers are also distributed in the heavily populated areas along I-5, I-405, and I-90. Currently there are eleven level I and four level II cardiac centers; and four level I, six level II, and five level III stroke centers in Central Region. The majority of the County's 2.19 million residents live in urban and suburban communities located along the I-5 and I-405 corridors where emergency medical hospital services are located (see Appendix 5.1).

The Central Region EMS and Trauma Council is made up of members of the EMS and Trauma community in King County, including representatives from hospital emergency departments, public and private EMS agencies, rehabilitation facilities, Seattle-King County Public Health, and the Northwest Healthcare Response Network. The council has an Executive Board that is made up of seven members elected by the council. The board is comprised of the following positions: chair, vice chair, secretary, treasurer, and three board members. All meetings are open public meetings, and members of the public are welcome and encouraged to attend. The council meets every other month, and the Executive Board meets monthly. Meetings may be held in a variety of formats including in person, conference call, or video call. The council also helps to coordinate quality assurance meetings, which are attended by representatives from trauma-designated hospitals and trauma-verified EMS agencies.

The Central Region has a mature and robust EMS system that began in 1969 when Leonard A. Cobb, M.D. and Chief Gordon Vickery, Seattle Fire Department, created Seattle's paramedic program, Medic One. Beginning with the EMS and Trauma System Act of 1990, trauma system elements mandated by RCW 70.168 and WAC 246-976-960 were incorporated into the existing EMS system. Local fire district levies, the Medic One Foundation, and the King County Medic One/EMS levy support prehospital training, and quality improvement activities. This financial support and oversight allows the Central Region EMS and Trauma Care Council to focus on access to emergency department services and overall EMS system performance. The Central Region EMS and Trauma Care Council receives its funding from the state Department of Health. Central Region representatives participate in a number of ad hoc workgroups, local and state committees and organizations related to EMS and Trauma Care in the region. Within the council, workgroups are formed on an ad hoc basis to discuss specific EMS system and patient care issues and to develop strategies to address those issues. Project-specific ad hoc committees have been formed on an as-needed basis. Outside of the council, members actively participate in regional partnerships and on state Technical Advisory Committees (TAC).

The Central Region EMS and Trauma Care Council accomplished numerous goals in the 2019-

2021 plan cycle. The strategic plan included some goals, objectives and strategies that are required in each plan cycle, and others that were unique to the specific needs of Central Region. The regional council reviewed recommended minimum and maximum numbers of trauma-designated hospitals and trauma-verified EMS agencies. The region voted to keep the levels of trauma-designated hospitals the same and to devote time and effort to census planning improvements. In the 2021 fiscal year, the region granted over $40,000 in grant funds to support regional training efforts, injury and violence prevention, public education, and Covid-19 response expenditures. The training grants supported public and non-profit agencies in their purchase of training supplies and materials. The types of materials purchased with these grants were many and varied. Some examples of items purchased included new CPR manikins, including specialty manikins to assist with pregnant women and infants, updated electronics for training facilities. During the review process, the council was able to fully fund grant applications from rural and underserved areas, allowing for greater support of those departments who needed it. Likewise, prevention grants funded a number of projects in the region, and were chosen based upon their relevance to the top causes of injury in King County- falls, drug addiction and mental health diagnoses, and gun violence. Specifically, funding went to projects providing falls prevention education for senior citizens in community-based and clinical settings.

Central Region has a robust Psychiatric Task Force, which has been very active in the goal of mitigating the impact of increasing census of psychiatric patients in emergency departments. The Task Force is working on a number of projects in pursuit of this goal, including coordinating a data collection project for the region for better measurement of the impact on the EMS and trauma system. This task force continues to meet during the Covid-19 pandemic to address behavioral health concerns in the context of the pandemic, which has put additional strain on hospital emergency departments and EMS agencies.

Because of the uniquely robust EMS system that exists in Central Region, the region contains few underserved geographical areas. The council has reviewed response and transport times and found, consistently, that the number and level of trauma-verified prehospital and hospital agencies matches the demand within the county. That said, there are unique challenges in Central Region, due to its ever-growing population and its population diversity. The EMS and Trauma Care Council is dedicated to addressing barriers to service, potential gaps in service and opportunities for improvement within the region. As such, in recent years we have actively established partnerships with smaller EMS agencies in rural areas that do not have the resources that larger urban agencies have. We have provided mini-grants to Enumclaw Fire, the Duval Fire Department, and Mountain View Fire and Rescue, among others. As part of a state-wide initiative to coordinate EMS and Trauma regions' work with emergency planning efforts, Central Region will continue to work with the Northwest Healthcare Response Network to coordinate EMS resources in emergency planning activities in the region. The council has also identified an opportunity to work more closely with the county's Office of Emergency Management so that the region and the county can operate with the highest levels of efficiency in the event of an emergency.

This 2021-2023 Central Region Strategic EMS & Trauma Care System Plan is made up of goals

adapted from the State Strategic EMS & Trauma Care System Plan. The objectives and strategies are developed by the Regional Council and its stakeholders to meet needs of the region.

The Central Region EMS & Trauma Care Council has adopted the following mission and vision statements:

Vision
Central Region has an efficient, well-coordinated statewide EMS & Trauma System which reduces death, disability, human suffering and costs due to injury and medical emergencies.

Mission
The Central Region EMS and Trauma Care Council's mission is to provide leadership and coordination of EMS community partners to reduce injury and to ensure provision of high-quality emergency medical and trauma care.

GOAL 1 Maintain, assess and increase emergency care resources.

Need and Distribution of Services

Hospital Care: There are four level III trauma centers and three level IV trauma centers in Central Region which are located in the heavily populated communities along the I-5 and I-405 corridors. There are two level V trauma centers; one is located along highway 410 in the mostly rural city of Enumclaw, and the other is in the rural area of Snoqualmie, near the I-90 mountain pass. The State's level one trauma center is located in Seattle and serves patients from Washington, Alaska, Montana and Idaho. Central Region will be reviewing trauma center performance measures for designation purposes during this plan cycle.

Categorized Cardiac and Stroke Centers are also distributed in the heavily populated areas along I-5, I-405, and I-90. Currently there are eleven level I and four level II cardiac centers; and four level I, six level II, and five level III stroke centers in Central Region.

Designated and categorized hospital services are listed by name and level of service in the regional Patient Care Procedures (PCPs) and EMS guidelines. Annually, the Regional Council will compare the PCPs with the current list of designated/categorized hospitals services on file with the Office of Community Health Systems to make sure the services listed in the PCPs are up to date. This process will ensure that prehospital agencies can transport their patient to the appropriate level of care.

Prehospital Care:

King County uses a tiered prehospital response system to ensure 9-1-1 calls receive medical care by the most appropriate care provider. Calls to 9-1-1 are received and triaged by professional dispatchers at five dispatch centers located throughout King County. The dispatchers are trained to identify the most appropriate level of care needed. Dispatchers provide pre-arrival instructions for most medical emergencies, and guide the caller through life-saving steps, including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) instructions, until the Medic One/EMS provider arrives. Basic Life Support (BLS) personnel are dispatched first to an incident, providing rapid basic life support that includes advanced first aid and CPR/AED to stabilize the patient. Staffed by fire department Emergency Medical Technicians (EMTs), BLS units arrive at the scene in less than five minutes on average.

Advanced Life Support (ALS/paramedic) personnel provide emergency medical care for critical or life-threatening injuries and illness. ALS units are dispatched simultaneous with BLS for life-threatening medical emergencies.

RCW 70.168.100 authorizes EMS Regions to identify the need for and recommend distribution and level of care of prehospital services to assure adequate availability and avoid inefficient duplication and lack of coordination of prehospital services within the region. The Regional Council also uses standardized methods provided by the Office of Community Health Systems and King County EMS Division prehospital data to determine the need and distribution of trauma verified prehospital services in King County. Need and distribution of prehospital services are reviewed during each Plan cycle.

Objective 1: By November 2022 the Regional Council will use methods developed by the Washington State Department of Health Office of Community Health Services and other data to determine the recommended minimum and maximum numbers and levels of trauma designated services (including pediatric and rehabilitation services) and provide recommendations to the Washington State Department of Health, Office of Community Health Systems and the EMS & Trauma Steering Committee.	**Strategy 1:** By July 2022 the Regional Council will review Central Region trauma data including population demographics to determine the recommended min/max number and levels of trauma designated facilities in Central Region (King County).
	Strategy 2: By September 2022 the Regional Council will vote on the recommended number and levels of trauma designated services in Central Region (King County).
	Strategy 3: By September 2022, the Regional Council will make recommendations to the Washington State Department of Health Office of Community Health Systems regarding the number and levels of trauma designated services in Central Region (King County).
	Strategy 4: By November 2022, the Regional Council will submit designated services min/max number and level recommendations to the EMS & Trauma Steering Committee as needed.
Objective 2: By May 2023 the Regional Council will use Washington State Department	**Strategy 1** By November 2022, the Regional Council and EMS Stakeholders will review EMS data including response and transport times, service demands, and

of Health, Office of Community Health Systems standardized methodology and King County EMS system data to determine the minimum and maximum numbers and levels of verified prehospital service in King County and provide recommendations to the Washington State Department of Health Office of Community Health Systems and the EMS & Trauma Steering Committee.	population to determine the minimum and maximum levels of verified prehospital services in Central Region (King County).
	Strategy 2: By January 2022 the Regional Council will vote on the recommended minimum and maximum numbers of verified ALS and BLS aid and ambulance services in Central Region (King County). The Regional Council will review the current AID-ALS minimum level of one and either change the minimum to zero or strategize how to assess the minimum services not being met. Assessment data will include, but is not limited to, dispatch times per annum and population growth since the prior review period. As necessary, needs assessments may be submitted by organizations wishing to change their trauma verification status.
	Strategy 3: By March 2023, the Regional Council will make recommendations to the Washington State Department of Health Office of Community Health Systems regarding the minimum and maximum numbers of verified ALS and BLS aid and ambulance services in Central Region (King County).
	Strategy 4: By May, 2023, the Regional Council will submit verified services min/max and level recommendations to the EMS & Trauma Steering Committee as needed to be attached to the 2023-2025 Central Region EMS Council Plan.
Objective 3: By December 2021 annually, the Regional Council will review the categorization levels for cardiac and stroke facilities to ensure consistency with Patient Care Procedures.	**Strategy 1:** By September 2021 annually, the Regional Council will review the list of currently categorized cardiac & stroke care centers and update the Patient Care Procedures (PCPs) so that they accurately reflect current appropriate cardiac & stroke patient destinations.
	Strategy 2: By November 2021 annually, the Regional Council will make recommendations to the Washington State Department of Health Office of Community Health Systems regarding revisions to the Region' s PCPs so that they accurately reflect current appropriate cardiac and stroke patient destinations.
	Strategy 3: By December 2021, annually, the Regional Council will submit revisions to the Region's PCPs to the EMS & Trauma Steering Committee as needed so

	that they accurately reflect current appropriate cardiac & stroke patient destinations.

GOAL 2
Support emergency preparedness activities.

Based upon past experience, the Central Region EMS and Trauma Care Council has determined that an opportunity exists for the region to collaborate and coordinate with emergency preparedness groups in the area, to facilitate the smooth functioning of the EMS and Trauma System in the event of an emergency. The region already works with the local healthcare coalition, the Northwest Healthcare Response Network (NWHRN), to share information at regional council meetings, and will continue to expand the collaborative work in the 2021-2023 planning period.

Objective 1: Coordinate with and participate in emergency preparedness and response to all hazardous incidents, patient transport, and planning initiatives to the extent possible of existing resources.	**Strategy 1:** At each regional council meeting, representatives from NWHRN will have the opportunity to present information to the region about emergency preparedness work that is happening in the region.
	Strategy 2: By September 2021, Regional Council staff will work to fill a council seat with a representative from King County's Office of Emergency Management.
	Strategy 3: Throughout the plan cycle, Regional Council staff will seek out opportunities for council members to actively participate in emergency preparedness activities in the region.

GOAL 3
Plan, implement, monitor and report outcomes of programs to reduce the incidence and impact of injuries, violence, and illness in the region.

The Central Region EMS Council uses DOH and King County EMS injury data to identify prevention needs and to develop activities to address those needs. During this Plan cycle, the Central Region EMS and Trauma Care Council will focus prevention activities on injury causes that are most prevalent in the region. In the 2019-2021 planning period, the top causes of injury included falls and suicide. In FY 2021, the council voted to provide over $40,000 in prevention mini-grants, which funded projects that addressed major causes of injury and death in the region. In past years, the council has supported projects targeted at reduction in patient falls, suicide prevention, and hemorrhage control in the event of a mass casualty incident, among others.

The Central Region collaborates with other EMS partners to develop and promote public health and public education messages for publication on the Regional Council website and through various media outlets. The council will continue to research and plan public education projects, in part through the continued distribution of the short educational film produced by the council in 2016.

Objective 1: By March 2023, the Regional Council will identify prevention needs and support evidence based and/or promising practices as resources are available.	**Strategy 1**: by November 2022, the Regional Council will review injury/illness data and identify injury and illness prevention needs in King County.
	Strategy 2: By January 2023, the Regional Council will develop activities to address one or more of the injury and/or illness prevention needs which were identified at the November 2022 Regional Council meeting.
	Strategy 3: By January 2023, the Regional Council will review outcomes data from council-supported prevention programs.
	Strategy 4: By March 2023, the Regional Council will add the identified injury prevention activities to the 2023-2025 Regional Plan.
Objective 2: By May 2022 annually, the Regional Council will collaborate with EMS stakeholders to educate the public and our partners on the Emergency Care System.	**Strategy 1** By September 2021, and throughout the plan cycle, the Regional Council and other EMS stakeholders will identify public education topics or issues to address.
	Strategy 2: By May 2022, and throughout the plan cycle, the Regional EMS Council and/or EMS partners will develop and release a pre-packaged public information message.

GOAL 4
Assess weaknesses and strengths of quality improvement programs in the region.

The Central Region EMS and Trauma Care Council has an active Quality Improvement (QI) group that usually meets three times per year. The QI group reviews case studies and specific incidents for education and improvement of emergency medical care in the region. During the Covid-19 pandemic, the QI meetings have diminished in frequency, due to scarce resources and increased time constraints on QI committee members. During the 2021-2023 plan cycle, the region will plan to re-establish regular QI meetings in the region.

Objective 1: By July 2023, the Regional Council will coordinate with regional partners to re-establish QI meetings at regular intervals throughout the year.	**Strategy 1:** In September 2021, The Regional Council staff will coordinate with QI committee leadership to determine a schedule for QI meetings that will work for members in the region.
	Strategy 2: By November 2021, The Regional Council will confirm and disperse the QI meeting schedule to regional council members.
	Strategy 3: By January 2022, and throughout the plan cycle, regional council staff will assist with scheduling, coordinating, and ensuring attendance at regional QI meetings based upon the established schedule.

GOAL 5
Promote regional system sustainability.

RCW 70.168 and WAC 246-976 identify the membership, and responsibilities of the regional and local EMS & trauma care councils. The Central Region EMS and Trauma Care Council membership includes local government, prehospital agencies, hospitals, the Medical Program Director, medical directors, rehabilitation facilities, and consumers. The Central Regional EMS and Trauma Care Council provides a forum for open discussion of EMS system and patient care issues and for sharing of information among EMS system partners. Workgroups are formed on an ad hoc basis to discuss specific EMS system and patient care issues and to develop strategies to address those issues.

Representatives from the Central Region participate on local and state planning committees, task forces, and workgroups so that EMS system issues, guidelines, plans, and information can be shared among local and state EMS partners.

In Central Region emergency medical technicians receive more than 140 hours of basic training and hospital experience with additional training in defibrillation. All paramedics in King County are graduates of the University of Washington Paramedic Training Program regardless of previous training. Paramedic candidates receive 2,500 hours of rigorous training, including classroom instruction, clinical rotations at Seattle Children's, University of Washington Medical Center and Harborview Medical Center, as well as extensive field training supervised by experienced senior paramedics. Dispatch, BLS and some ALS continuing education is provided by the King County EMS Online program which is funded through the King County Medic One/EMS levy. Paramedics receive 30 hours of continuing medical education classes each year along with surgical airway management laboratories and advanced cardiac life support and pediatric advanced life support classes. Funding for paramedic continuing education is funded through the Medic One Foundation and through the Medic One/EMS Levy. During each Plan cycle, the Central Region EMS Council surveys prehospital agencies to determine education and training needs not met through EMS online and other trainings that are funded through the EMS levy. Throughout the July 1, 2021-June

30, 2023 plan cycle, the Central Region EMS Council will appropriate funding for additional training based on need and financial resources.

Regional Patient Care Procedures (PCPs) have been developed to provide specific directions for how the trauma system functions within the Central Region. PCPs are developed by the King County Medical Program Director in collaboration with local medical directors and the Central Region Council to ensure consistency with the Regional Patient Care Procedures.

Local fire district levies, the Medic One Foundation, and the King County Medic One/EMS levy support prehospital training, and quality improvement activities. This financial support and oversight allows the Central Region EMS and Trauma Care Council to focus on access to emergency department services and overall EMS system performance. During this Plan cycle:

- The Central Region EMS & Trauma Care Council will continue to monitor hospital compliance with the Central Region No Diversion Policy and the regional WaTrac reporting policy.
- The Psychiatric Patient Care Task Force will continue to monitor psychiatric patient care access and work toward finding a long term solution to providing adequate psychiatric patient care in King County.
- The council will develop action plans to address increasing patient census in hospital emergency departments.

Objective 1. By July 2021 and throughout the plan cycle Central Region hospitals will continue to support a no diversion policy.	**Strategy 1:** By July 2021 and throughout the Plan cycle, Regional Council staff will monitor hospital diversion as reported by WaTrac and provide bi-monthly reports to hospitals.
	Strategy 2: By July 2021 and throughout the Plan cycle, Regional Council staff will monitor hospital ED status reports on WaTrac and provide bi-monthly reports to hospitals on reporting frequency compliance and reporting errors.
Objective 2: By July 2021 and throughout the plan cycle, the Regional Council will monitor psychiatric patient access to appropriate care in Central Region.	**Strategy 1:** By July 2021 and throughout the plan cycle, Regional Council staff will schedule quarterly Psychiatric Patient Task Force (PPTF) meetings.
	Strategy 2: By July 2021, and throughout the Plan cycle, the PPTF will discuss issues which affect psychiatric patient care in the region
	Strategy 3: By July 2021 and throughout the Plan cycle, the PPTF will discuss best practices for addressing psychiatric patient care issues that have been identified
	Strategy 4: By July 2021 and throughout the Plan cycle the PPTF will develop action plans to address

	psychiatric patient care issues which have been identified.
	Strategy 5: By July 2021 and throughout the Plan cycle the Regional Council will evaluate the impact of the action plans on psychiatric patient care in the region.
Objective 3: By September 2021, and throughout the plan cycle, the Regional Council will develop action plans to address increasing patient census in hospital emergency departments.	**Strategy 1:** By September 2021, The Regional Council will discuss strategies to mitigate high patient census in King County.
	Strategy 2: By November 2021, The Regional Council will develop action plans, if applicable, to mitigate the effects of high patient census in King County.
	Strategy 3: By January 2022, the Regional Council will implement action plans, if applicable, to mitigate the effects of high patient census in King County.
	Strategy 4: Throughout the remainder of the plan cycle, the council will evaluate the impact of the action plans previously developed.
Objective 4: During the Plan cycle the Regional Council will facilitate the exchange of information throughout the emergency care system.	**Strategy 1:** By July 2021 and throughout the Plan cycle, the Regional Council will provide meeting rooms for the Regional Council and workgroups.
	Strategy 2: By July 2021 and throughout the Plan cycle, Regional Council members will participate in EMS stakeholder meetings including: King County EMS Advisory Council, Medical Directors Committee, Northwest Healthcare Response Network, EMS & Trauma Steering Committee, and associated Technical Advisory Committees and share information with the Regional Council at regularly scheduled meetings.
	Strategy 3: By July 2021 and throughout the Plan cycle, meeting agendas, minutes, newsletters, reports and other items will be provided to regional EMS stakeholders in advance of each meeting through email distribution.
	Strategy 4: By July 2021 and throughout the Plan cycle, Regional Council staff and EMS stakeholders will bring EMS system and patient care issues forward to the EMS and Trauma Care Steering Committee TACs as necessary.
Objective 5: During the Plan cycle, the Regional Council will work with the Washington State Department of Health	**Strategy 1:** By August 2021 annually, the Regional Council will develop an annual budget and submit the annual budget to the Washington State Department of Health Office of Community Health Systems.

Office of Community Health Systems and the State Auditor's Office to ensure the Regional Council business structure and practices remain compliant with RCW.	**Strategy 2:** By October 2021 annually, the Regional Council will submit the previous year's financial information and related schedules to the Washington State Auditor's Office.
	Strategy 3: By January 2022 annually, the Regional Council will review semi-annual budget vs. actual revenues & expenditures and submit a report to the Washington State Department of Health Office of Community Health Systems.
	Strategy 4: By June 2022 annually, the Regional Council will review the end of year annual budget vs. actual revenues & expenditures and submit a report to the Washington State Department of Health Office of Community Health Systems.
	Strategy 5: By July 2022 annually, the Regional Council Board will review the Regional Council financial policies and Board/Staff roles and responsibilities.
Objective 6: At Regional Council meetings, the Regional Council will identify patient care issues and develop strategies to address the patient care issues.	**Strategy 1:** By July 2021 and throughout the Plan cycle, the Regional Council will discuss issues which affect patient care in the region
	Strategy 2: By July 2021 and throughout the Plan cycle, the Regional Council will discuss best practices for addressing patient care issues that have been identified
	Strategy 3: By July 2021 and throughout the Plan cycle the Regional Council will develop action plans to address patient care issues which have been identified.
	Strategy 4: By July 2021 and throughout the Plan cycle the Regional Council will evaluate the impact of the action plans on patient care in the region.
Objective 7: By May 2023, the Regional Council will develop a FY 2023-2025 strategic plan.	**Strategy 1:** By November 2022, the Regional Council and Regional Council Board will begin developing a FY 2023-2025strategic plan.
	Strategy 2: By March 2023, the Regional Council will approve the plan
	Strategy 3: By March 2023, the Council approved plan will be submitted to the Office of Community Health Systems.
	Strategy 4: By May 2023, the Regional Council will submit the FY 2023-2025 plan to the EMS & Trauma Steering Committee.

Objective 8: By October 2021 annually, the Regional Council will allocate available funding to support prehospital training needs.	**Strategy 1:** By May 2021 annually, the Regional Council will develop a budget for prehospital training support.
	Strategy 2: By July 2021 annually, the Regional Council will survey EMS agencies in King County to determine training needs.
	Strategy 3: By September 2021 annually, the Regional Council will review the survey results and prioritize training needs.
	Strategy 4: By October 2021 annually, the Regional Council will allocate available funding for prioritized training needs.
Objective 9: By May 2022 annually, the Regional Council will provide any new or revised Patient Care Procedures to the Washington State Department of Health Office of Community Health Systems and the EMS & Trauma Steering Committee for review and approval.	**Strategy 1:** By January 2022 annually, the Regional Council, MPD and other EMS stakeholders will review Central Region Patient Care Procedures and make revisions as necessary.
	Strategy 2: By March 2022 annually, the Regional Council will submit any revised Patient Care Procedures to the Washington State Department of Health Office of Community Health Systems for review and approval.
	Strategy 3: By May 2022 annually, the Regional Council will submit any revised Patient Care Procedures to the EMS & Trauma Steering Committee as needed.
Objective 10: By September 2021, annually, the Regional Council will review the Key Performance Indicators developed by the Prehospital TAC and assess prehospital performance as necessary.	**Strategy 1:** By July 2021, annually, Regional Council staff will coordinate with the MPD to review Key Performance Indicators and assess prehospital performance as necessary.
	Strategy 2: By September 2021, annually, any recommendations for performance improvements will be communicated to the appropriate prehospital agencies.
	Strategy 3: By September 2021, annually, any recommendations for performance improvements that affect all prehospital members of the Regional Council will be communicated and addressed at a Regional Council meeting.

Appendices:

Appendix 1: Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma

Care Services (General Acute Trauma Services)

Level	State Approved		Current Status
	Min	Max	
I	1	2	1
II	0	0	0
III	4	4	4
IV	3	3	3
V	1	2	1
II P	0	0	0
III P	0	0	0

Appendix 2: Current Stroke and Cardiac Categorized Facilities in Central Region*

Level	Number of Facilities
Cardiac: Level I	12
Cardiac: Level 2	4
Stroke: Level 1	4
Stroke: Level 2	7
Stroke: Level 3	5

*Numbers are current as of date submitted. For real-time numbers, please see: Cardiac and Stroke Categorized Facilities

Appendix 3: Approved Minimum/Maximum (Min/Max) numbers of Designated Rehabilitation Trauma Care Services

Level	State Approved		Current Status
	Min	Max	
I	0	0	0
II	4	6	1
III	0	1	0

Appendices 4 and 5: Approved Min/Max numbers of Verified Trauma Services by Level and Type by County*

County (Name)	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (# Verified for each Service Type)
	Aid – BLS	1	5	5
	Aid –ILS	0	0	0

	Aid – ALS	1	1	0
	Amb –BLS	1	25	25
	Amb – ILS	0	0	0
	Amb - ALS	5	5	5

*Numbers current as of date submitted. For real-time numbers, please see: Trauma Designated Services List

Appendix 6: Trauma Response Areas by County

County (name)	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in each Response Areas * use key
King	Primary Zone 1	From NW border of Seattle; north to Snohomish County border; east along Snohomish County border to NE corner of FD 45; south along the eastern borders of FD 45 and Eastside Fire & Rescue and FD 27 FD 27 and continuing along the eastern border of Eastside Fire & Rescue, FD 27 borders to the NE border of Maple Valley Fire & Life Safety; west to NW border of Renton FD, north along east side of Lake Washington, including Mercer Island to the Northeast border of Seattle and west to NW border of Seattle.	A-1 D-10 F-3
King	NE Zone 1	Boundaries of FD 50	D-1
King	E Zone 1	Boundaries of FD 51	D-1
King	Zone 3	South border of Seattle and south end of Lake Washington along north border of Renton and Maple Valley, east: along Kittitas County Border; south along Pierce County border; west along Puget Sound including Vashon Island.	A-3 D-11 F-2
King	Zone 5	City of Seattle	A-1 D-1 F-1
King	Zone SW	North from SE border of Zone 3 along eastern borders of Zone 3 and Primary Zone 1 to the intersection of Primary Zone 1 and I-90; east along I-90 to intersection of 1-90 and E Zone 1; around the southern border of E Zone 1 to Kittitas County border; south along Kittitas County border to Pierce County border; west along Pierce County border to SE corner of Zone 3.	No designated service

King	Zone NW	From intersection of I-90 and Primary Zone 1; North along the eastern border of Primary Zone 1 to Snohomish County Border; east along Snohomish County border to NW border of NE Zone 1; south along western border of NE Zone 1 to SW corner of NE Zone 1; east along southern border of NE Zone 1 to Kittitas County border; south along Kittitas County border to intersection of E Zone 1 and Kittitas border; west and south around E Zone 1 to intersection of I-90 and E Zone 1, along I-90 to intersection of I-90 and Primary Zone 1.	No designated service

Key: For each level the type and number should be indicated

Aid-BLS = A Ambulance-BLS = D Aid-ALS = C
Ambulance-ALS = F Aid-ILS = B Ambulance-ILS = E

Central Region Trauma Response Area Map:

http://ww4.doh.wa.gov/gis/pdf/ems_central.pdf

Appendix 7: Link to Approved EMS Training Programs

BLS Training, King County EMS: https://www.kingcounty.gov/depts/health/emergency-medical-services/training.aspx

Paramedic Training:

https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EMSProviderEducation/ParamedicPrograms

CENTRAL REGION EMS AND TRAUMA CARE SYSTEM STRATEGIC PLAN 2021-2023

"Washington State Department of Health - Health Systems Quality Assurance - Office of Community Health Systems – Central Region EMS and Trauma Care Council"

TABLE OF CONTENTS

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Department of Health, Emergency Care System

To Request Additional Copies (206) 909-8038

REGULATIONS

The following regulations provide guidance on subject matter contained in this document. Please note, that this is not an inclusive list. For more information please contact a Department of Health Emergency Care System representative.

1.1 REVISED CODE OF WASHINGTON (RCW):

- **RCW 18.73** – Emergency medical care and transportation services
  - RCW 18.73.030 - Definitions
- **RCW Chapter 70.168** – Statewide Trauma Care System
  - RCW 70.168.015 – Definitions
  - RCW 70.168.100 – Regional Emergency medical Services and Trauma Care Councils
  - RCW 70.168.170 – Ambulance services – Work Group – Patient transportation – Mental health or chemical dependency services

1.2 WASHINGTON ADMINISTRATIVE CODE (WAC):

- **WAC Chapter 246-976** – Emergency Medical Services and Trauma Care Systems
  - WAC 246-976-920 – Medical Program Director
  - WAC 246-976-960 – Regional emergency medical services and trauma care councils
  - WAC 246-976-970 – Local emergency medical services and trauma care councils

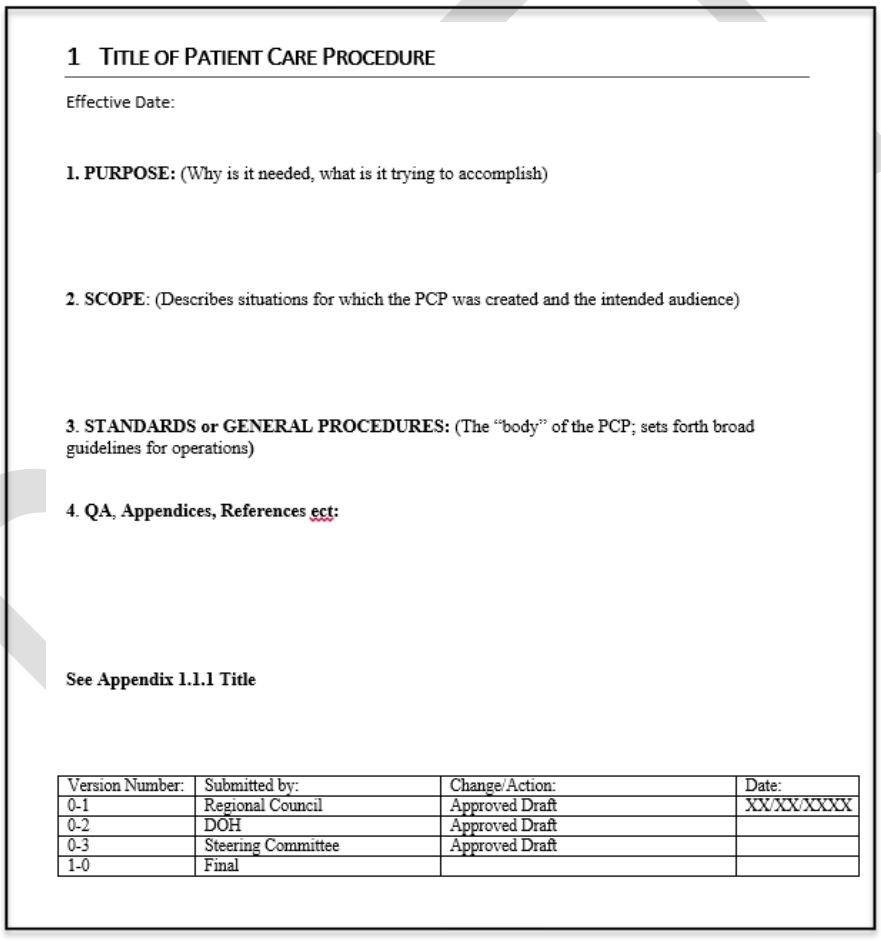
ANATOMY OF A PCP

RCW 18.73.030 – Defines a "Patient Care Procedure".

Other helpful definitions when building the anatomy of the PCP:

- **Purpose:** The purpose explains why it is needed and what it is trying to accomplish
- **Scope:** Describes the situations for which the PCP was created and the intended audience
- **Standards or General Procedures**: The "body" of the PCP, it sets forth broad guidelines for operations

Example:



1 TITLE OF PATIENT CARE PROCEDURE

Effective Date:

1. PURPOSE: (Why is it needed, what is it trying to accomplish)

2. SCOPE: (Describes situations for which the PCP was created and the intended audience)

3. STANDARDS or GENERAL PROCEDURES: (The "body" of the PCP; sets forth broad guidelines for operations)

4. QA, Appendices, References ect:

See Appendix 1.1.1 Title

Version Number:	Submitted by:	Change/Action:	Date:
0-1	Regional Council	Approved Draft	XX/XX/XXXX
0-2	DOH	Approved Draft	
0-3	Steering Committee	Approved Draft	
1-0	Final		

• LEVEL OF MEDICAL CARE PERSONNEL TO BE DISPATCHED TO AN EMERGENCY SCENE

Effective Date: 2009

1. PURPOSE: To define guidelines for triage of trauma patients in the region.

2. **SCOPE**: This PCP applies to all 911 calls and EMS and trauma patients in the region.

3. **GENERAL PROCEDURES:**

Dispatch

Dispatch centers are accessed through the enhanced 911 system. Regional dispatch centers dispatch EMS units in accordance with King County Criteria Based Dispatch Guidelines. Seattle dispatchers use Seattle Fire Department Dispatch Guidelines. Dispatchers provide bystander emergency medical instructions while EMS units are in route to the scene.

The Central Region EMS Trauma Committee requires that emergency dispatching protocols be based on medical criteria. All EMS dispatching guidelines and protocols must be approved by the Program Medical Director of King County EMS in consultation with the Medical Program Directors of the paramedic programs within the County

Basic Life Support

Basic Life Support response is provided by city and county fire department units staffed by EMTs or private ambulance services staffed by EMTs. The nearest unit to an emergency scene will be dispatched following established dispatch guidelines.

BLS Code Red Response and Transport

Note: Primary responding EMS personnel refers to fire department EMT personnel or paramedics response originating as part of the 911 EMS system. Emergency response refers to travel with light and sirens. The following procedures are intended to maximize patient safety and minimize risk to life and limb. Common sense and good judgment must be used at all times.

1) The response mode from primary BLS response (fire department EMT personnel) shall be based on information made available to the EMS dispatchers and the decision for mode of travel made according to dispatch guidelines.
2) The default mode for travel to the scene for non-primary BLS responders shall be by non-emergency response unless a specific response for code-red (emergency response) is made by primary responding EMS personnel at the scene or specific protocols or contracts defining response modes exist between fire departments or private agencies and private ambulance companies.
3) The default mode for BLS transport from scene to hospital shall be by non-emergency response unless a specific response for code-red transport is made by primary responding EMS personnel at the scene.
4) If a patient undergoing BLS transport to hospital deteriorates, the BLS personnel should contact the EMS dispatcher and ask for paramedic assistance, unless documentary evidence exists to travel code-red to hospital (such as travel to hospital can occur faster than waiting for paramedic assistance).

Advanced Life Support

The paramedic unit nearest the emergency scene is simultaneously dispatched consistent with dispatch guidelines. Paramedic units provide advanced life support transport.

Wilderness

Wilderness response is directed by the King County Sheriff Search and Rescue Coordinator. EMS units may be dispatched to a staging area depending on the nature and location of the incident. Transportation of trauma patients from wilderness areas is primarily accomplished by helicopter. The Level I trauma center should be the primary destination of these patients.

4. APPENDICES: N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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			☐ Major ☐ Minor
			☐ Major ☐ Minor

2 GUIDELINES FOR RENDEZVOUS WITH AGENCIES THAT OFFER HIGHER LEVEL OF CARE

The Central Region EMS and Trauma Care Council does not currently have this patient care procedure.

3 AIR MEDICAL SERVICES - ACTIVATION AND UTILIZATION

Effective Date: 2019

1. **PURPOSE:**

   Air Medical Service activation and utilization provides expeditious transport of critically ill or injured patients to the appropriate hospital including designated/categorized receiving facilities.

2. **SCOPE**:

   Licensed and trauma verified aid and/or ambulance services utilize the county protocols and county operating procedures (COPs) consistent with current "WA Statewide Recommendations for EMS Use Air Medical" (within the WA State Air Medical Plan) to identify and direct activation and utilization of air medical services.

3. **GENERAL PROCEDURES:** (content based on State Air Medical Procedure)
   a. For scene transport to be efficacious and optimize patient outcome, the air medical response should take significantly less time than it takes to travel by ground to the closest appropriate facility. Another strong consideration should be given to activating the helicopter from the scene, and rendezvous at the local hospital. This decision should be made as per local COPS in conjunction with local medical control.
   b. Responders should involve dispatch to contact and activate air medical response to maintain system safety and integrity. The dispatching agency will provide the helicopter with the correct radio frequency to use for contacting EMS ground units.
   c. Responding EMS service may activate air medical service prior to arrival on scene based on dispatch information or upon arrival on scene based on initial assessment.
   d. Air medical service will provide ETA of available fully staffed closest air ambulance.
   e. The final patient transport and destination decisions will be made on the scene.
   f. Air medical service will notify PSAP/dispatch when activated by a mechanism outside the emergency dispatch system.

   Air Medical transport is recommended for the following:
   Trauma – patient condition identified as a major trauma per the trauma triage tool. (see link to the WA Trauma Triage Destination Procedure in appendix)

   Non-trauma:
   a. Any patient airway that cannot be maintained.

b. Patient with cardiac disease and is experiencing a progressively deteriorating course, is unstable, and/or requires measures not available en route (e.g. ALS level care, cardiac catheterization, thrombolytic therapy.)
c. Patient is experiencing a severe neurological illness requiring neurosurgical or other intervention that is not available en route. (CVA, uncontrolled seizures, etc.)

Follow local COPs for exception and exclusion criteria.

4. **APPENDICES:**

Link to DOH website:

WA State Air Medical Plan

https://www.doh.wa.gov/portals/1/Documents/Pubs/530129.pdf

WA Trauma Triage Destination Procedure:

https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf

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Regional Council	Approved Draft		☐ Major ☐ Minor
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4 ON SCENE COMMAND

The Central Region EMS and Trauma Care Council does not currently have this patient care procedure.

5 PREHOSPITAL TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2009

1. PURPOSE: This patient care procedure provides guidance for patient triage and determination of the appropriate hospital destination.

2. **SCOPE**: This procedure applies to prehospital personnel in the field.

3. **GENERAL PROCEDURES:**

l. Prehospital care providers respect the right of the patient to choose a hospital destination and will make reasonable efforts to assure that choice is observed. Alternately and under ADAPT guidelines, fire department-based BLS providers may transport or suggest transport of patients to non-hospital settings such as stand alone emergency rooms and clinics. Reference Appendix II – ADAPT Guidelines

Factors including patient's choices may be:

1. Personal Preference
2. Personal physician's affiliation
3. HMO or preferred provider

Modifying factors which may influence the prehospital provider's response:

1. Patient unable to communicate choice

2. Unstable patient who would benefit from transportation to nearest hospital or to hospital providing specialized services.

3. Transport to patient's choice of hospital would put medic unit or aid car out of service for extended period and alternative transport is not appropriate or available.

II. Prehospital providers should transport unstable patients, i.e. compromised airway, post arrest, shock from non-traumatic causes, etc. to the nearest hospital able to accept the patient.

II. Emergency patients requiring specialized care such as hyperbaric treatment, neonatal ICU, or high-risk OB care should be transported to the nearest hospital able to provide such care.

IV. When in doubt, prehospital care providers should contact online medical control.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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5.1 TRAUMA TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2009

1. PURPOSE: These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which trauma center will receive the patient.

2. **SCOPE**: This procedure is for prehospital care providers and their medical control physicians.

3. **GENERAL PROCEDURES:**

1. For patients meeting the inclusion criteria of the State of Washington Prehospital Trauma Triage (Destination) Procedure, prehospital providers will contact online medical control of the closest trauma center or Harborview Medical Center (Reference: Designated Trauma Centers in King County/Paramedic Response Area). Medical Control or Harborview Medical Center will determine patient destination consistent with the State of Washington Prehospital Trauma Triage (Destination) Procedure.

2. The primary destination of pediatric patients meeting the inclusion criteria of the State of Washington Prehospital Trauma Triage (Destination) Procedure is the Level I trauma center.

3. Unstable trauma patients should be managed consistent with the State of Washington Prehospital Trauma Triage (Destination) Procedure. Unstable trauma patients are those needing a patent airway or who may benefit from the initiation of fluid resuscitation. EMS providers who are unable to secure an airway or establish an intravenous line should consider these factors in the following order:

a. time to arrival of responding medic unit
b. time to rendezvous with responding medic unit
c. time to nearest trauma center
d. time to arrival of Airlift
e. time to nearest hospital with 24 hr emergency room
f. unusual events such as earthquakes and other natural disasters

4. Patient destination decisions will be monitored by the Regional Quality Assurance Committee.

The goal in treating the unstable trauma patient is to provide potential life saving intervention and transportation to the highest-level trauma center able to provide definitive treatment. Ideally these interventions will be performed in a manner that does not unduly delay transport of a patient to the appropriate level of trauma center. This may require EMS providers to stop at a local hospital to stabilize and then transfer the patient to the trauma center.

Consistent with inter-facility transfer agreements, trauma patients stabilized at non-designated hospitals should be transferred to a trauma center as soon as possible. Patients stabilized at Level III or IV trauma centers and meeting the criteria for triage to the Level I trauma center should be transferred as necessary. The State's Level I trauma center is:

Harborview Medical Center
325 Ninth Avenue
Seattle, WA 98104

All Central Region Trauma Care Facilities are as follows:

Level I Trauma Center (Pediatric and Adult)
Harborview Medical Center

Level III Trauma Centers
Multicare Auburn Medical Center
EvergreenHealth Medical Center
Overlake Hospital Medical Center
Valley Medical Center

Level IV Trauma Centers
Highline Community Hospital
Northwest Hospital
St. Francis Hospital

Level V Trauma Center
St. Elizabeth Hospital
Snoqualmie Valley Hospital

4. APPENDICES:

DOH guidance document: Prehospital Trauma Triage and Destination Procedure.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	01/01/2021	☐ Major ☐ Minor
			☐ Major ☐ Minor
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			☐ Major ☐ Minor

5.2 CARDIAC TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2018

1. PURPOSE: Provides guidance for the prehospital care and transport of cardiac patients in Central Region.

2. **SCOPE**: This procedure applies to prehospital providers caring for cardiac patients.

3. **GENERAL PROCEDURES:**
Cardiac Patient Triage and Destination

These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which Cardiac Center will receive the patient.

1. Prehospital providers will contact established medical control. Medical Control will determine patient destination consistent with Washington State Cardiac Patient Care Triage Destination Procedure.

2. Patients shall be managed consistent with the State of Washington Prehospital Cardiac Triage Destination Procedure.

3. Patient destination decisions and patient outcome will be monitored by the Regional Quality Assurance Committee

Current Approved Cardiac Care Centers

Level I
- Multicare Auburn Regional Medical Center
- Evergreen Hospital Medical Center
- Harborview Medical Center
- Highline Medical Center
- Northwest Hospital Medical Center
- Overlake Hospital Medical Center
- St. Francis Hospital
- Swedish Cherry Hill
- University of Washington Medical Center
- Valley Medical Center
- Virginia Mason Medical Center
- Swedish- Issaquah

Level II
- Swedish First Hill
- Snoqualmie Valley Medical Center
- St. Elizabeth Hospital

Swedish Ballard

4. **APPENDICES:** DOH guidance document on prehospital cardiac care.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
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5.3 STROKE TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2018

1. PURPOSE: To provide prehospital guidance on the transport and care of stroke patients.

2. **SCOPE**: This procedure is appropriate for prehospital providers who are caring for stroke patients.

3. **GENERAL PROCEDURES:** Stroke Patient Triage and Destination

These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which Stroke Center will receive the patient.
EMTs shall transport patient to the closest appropriate level Stroke Center consistent with the Washington State Stroke Patient Care Triage Destination Procedure and with regard to the patient or family preference. "

1. For all patients with suspected stroke, EMS personnel will contact the closest Level 1 or II or III stroke center and describe the situation. The hospital will advise EMS of appropriate patient destination consistent with the Washington State Patient Care Triage Destination Procedure.

2. For unstable stroke patients, EMTs shall request Paramedic assistance

3. Paramedics shall contact established medical control. Medical Control will determine patient destination consistent with Washington State Stroke Patient Care Triage Destination Procedure.

4. Patients should be managed consistent with the King County ALS Protocols and State of Washington Prehospital Stroke Triage Destination Procedure.

5. Patients should be managed consistent with the King County ALS Protocols and State of Washington Prehospital Stroke Triage Destination Procedure.

6. Patient destination decisions and patient outcome will be monitored by the Regional Quality Assurance Committee

Current Approved Stroke Centers

Level 1 Harborview Medical Center
Northwest Hospital Medical Center
Swedish Cherry Hill
Virginia Mason Medical Center

Level II	Multicare Auburn Regional Medical Center Evergreen Hospital Medical Center Highline Medical Center Overlake Hospital Medical Center Swedish First Hill Valley Medical Center
Level III	Snoqualmie Valley Hospital St. Elizabeth Hospital St. Francis Hospital Swedish – Ballard University of Washington Medical Center

4. **APPENDICES:** See stroke triage tool on the next page.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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2019 King County Prehospital Stroke Triage Procedure

STEP 1: Assess Likelihood of Stroke

- Numbness or weakness of the face, arm, or leg, especially on one side of the body
- Confusion, trouble speaking, or understanding
- Trouble seeing in one or both eyes
- Trouble walking, dizziness, loss of balance, or coordination
- Severe headache with no known cause

If any of above, proceed to STEP 2, otherwise, transport per regional/county operating procedures

STEP 2: Perform F.A.S.T. Assessment (positive if any of Face/Arms/Speech abnormal)

- **Face**: Unilateral facial droop
- **Arms**: Unilateral arm drift or weakness
- **Speech**: Abnormal or slurred
- **Time**: Best estimate of Time Last Known Well =_____

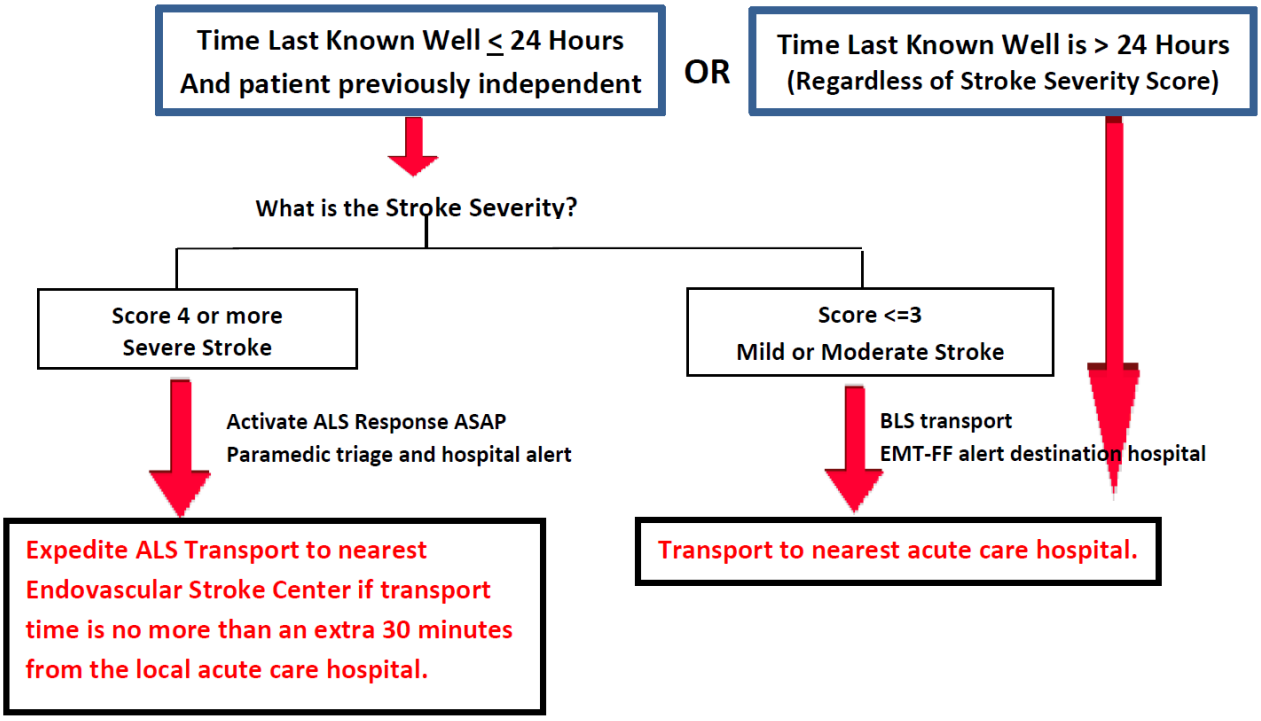
If FAST negative transport per regional operating procedures

STEP 3: If F.A.S.T Positive - Calculate Stroke Severity Score

Facial Droop:	Absent 0	Present	1		
Arm Drift:	Absent 0	Drifts	1	Falls Rapidly	2
Grip Strength:	Normal 0	Weak	1	No Grip	2

Total Stroke Severity Score = _____ (max. 5 points)

STEP 4: Determine Destination: Time Last Known Well & Stroke Severity Score



Exclude persons with chronic illness that makes them bedbound – for example those with advanced dementia or longstanding medical illness who require substantial assistance for basic life activities. These patients should proceed to local hospital regardless of stroke severity or last known well status.

5.4 MENTAL HEALTH AND CHEMICAL DEPENDENCY DESTINATION PROCEDURE

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

5.5 PREHOSPITAL TRIAGE AND DESTINATION PROCEDURE - OTHER

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

6 EMS/MEDICAL CONTROL COMMUNICATIONS

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

7 HOSPITAL DIVERSION

Effective Date: 2009

1. PURPOSE: This procedure outlines Central Region's no-divert policy.

2. **SCOPE**: This procedure is appropriate for times of high patient census, and is meant for hospital and prehospital personnel.

3. **GENERAL PROCEDURES:**
Ambulance diversion is defined as an active statement by a hospital, whether verbal or via WaTrac ED Status, that patients arriving by ambulance will not be accepted. King County hospitals have unanimously adopted a No Diversion Policy for all medical and surgical patients effective May 31, 2011.

Hospitals may close their emergency departments only in an internal emergency such as facility damage or lockdown. There may be circumstances where an advisory to prehospital agencies will allow ambulance services to make transport destination decisions in the best interest of their patient; for example when a hospital reports "CT down" or "specialty care unavailable." Prehospital service may use this information to make an appropriate transport decision. The decision on where to transport a patient will remain at the discretion of the prehospital provider unless directed to a specific facility by medical control.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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8 CROSS BORDER TRANSPORT

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

9 INTER-FACILITY TRANSPORT PROCEDURE

Effective Date: 2009

1. PURPOSE: To establish guidelines for the transport of patients between facilities within Central Region.

2. **SCOPE**: This procedure is relevant for hospital emergency department personnel and EMS agencies who may transfer a patient from one facility to another within the region.

3. **GENERAL PROCEDURES:**

Private ALS and BLS agencies provide interfacility patient transfers at the direction of the hospital initiating the transfer. All interfacility patient transfers shall be consistent with the transfer procedures in WAC 246-976-890.

Level III, Level IV, and Level V trauma centers will transfer patients to the State Level I trauma center when appropriate. The State's Level I trauma center is:

Harborview Medical Center
325 Ninth Avenue
Seattle, WA 98104

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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			☐ Major ☐ Minor

10 PROCEDURES TO HANDLE TYPES AND VOLUMES OF PATIENTS THAT EXCEED REGIONAL RESOURCES

10.1 MCI

Effective Date: 2009

1. PURPOSE: To establish procedures for patient transport in the event of a mass casualty incident.

2. **SCOPE**: This procedure is relevant to EMS and hospital personnel in the region in the event of a mass casualty incident.

3. **GENERAL PROCEDURES:**
The Central Region has adequate resources to meet normal trauma patient volumes. The Quality Assurance Committee monitors mechanism of injury and patient volumes.

Large Multiple Casualty Incidents may require the triage of patients to non-designated King County hospitals or to trauma centers in adjacent counties.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
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10.2 ALL HAZARDS- MCI AND SEVERE BURNS

Effective Date: 2009

1. PURPOSE: Provides guidance for transport and care of patients in an MCI who may have suffered severe burns and need specialized care.

2. **SCOPE**: This procedure is appropriate for EMS teams in an MCI in which many patients suffer severe burns.

3. **GENERAL PROCEDURES:**

I. STANDARD: During a mass casualty incident (MCI) with severely burned adult and pediatric patients,

1. All verified ambulance and verified aid services shall respond to an MCI per the King County Fire Chief's MCI Plan
2. All licensed ambulance and licensed aid services shall assist during an MCI per King County Fire Chief's MCI Plan when activated by incident command through dispatch in support of the King County Fire Chief's MCI Plan and/or in support of verified EMS services
3. All EMS certified personnel shall assist during an MCI per King County Fire Chief's MCI Plans when requested by incident command through dispatch in support of the King County Fire Chief's MCI Plan and/or in support of verified EMS services
4. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
5. All EMS agencies working during an MCI event shall operate within the Incident Command System as identified in local protocol and MCI plan.

II. PURPOSE:

1. To develop and communicate the information of regional trauma plan section VII prior to an MCI.
2. To implement King County Fire Chief's MCI Plan during an MCI.
3. To provide trauma and burn care to at least 50 severely injured adult and pediatric patients per region.
4. To provide safe mass transportation with pre-identified medical staff, equipment, and supplies per mass transport vehicle.

III. PROCEDURES:

1. Incident Command shall follow the King County Fire Chief's MCI Plan and will notify Disaster Medical Control Center (DMCC) when an MCI condition exists, including factors identifying severe burn injuries and number of adult/pediatric patients.
2. Medical program directors agree that protocols being used by responding agencies shall continue to be used throughout transport of patients regardless of county, state or country.
3. EMS personnel may use the "Prehospital Mass Casualty Incident (MCI) general Algorithm during the MCI incident.

A. The "SAMPLE ONLY" algorithm is intended as a boilerplate or skeleton outline only. It is not intended as a state directed requirement.

B. the DRAFT-SAMPLE Algorithm is attached on the next page.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
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4. APPENDICES:

Prehospital Mass Causality Incident (MCI) General Algorithm

1. Receive dispatch
2. Respond as directed
3. Arrive at scene
4. Determine mass causality conditions exist
5. Establish Incident Command (IC)
6. Scene assessment and size-up

CBRNE	NON-CBRNE
1) Notify the DMCC and IC of CBRNE situation 2) Standby for HazMat/LE to clear scene 3) Don PPE if needed 4) Establish hot, warm, and cold zones 5) Begin Initial Triage of Patients 6) Notify medical control and IC of patients conditions 7) Decontaminate patients as needed 8) Begin initial treatment 9) Follow PCPs and MCI Plans 10) Request additional resources that may include activating MAA 11) Initiate patient transport to medical centers as directed by medical control and/or the DMCC 12) Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary)	Notify medical control and/or the DMCC and local Emergency Management Office 1) Ensure scene is safe 2) Begin Initial Triage and Treatment of Critically Injured Patients 3) Establish a staging area 4) Follow EMS patient care procedures (PCPs) and MCI Plans 5) Request additional resources that may include activating MAA 6) Initiate patient transport to medical centers as directed by medical control and/or the DMCC 7) Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary)

Prepare transport vehicle to return to service

10.3 OTHER

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

A) REGION SPECIFIC PATIENT CARE PROCEDURES: ACTIVATION OF TRAUMA TEAM

Effective Date: 2009

1. PURPOSE: To provide a general guideline for hospital facilities' activation of their trauma team for incoming patients.

2. **SCOPE**: Applies to hospital personnel.

3. **GENERAL PROCEDURES:**
Trauma team activation is accomplished at the time of contact with Medical Control. Online medical control at the receiving trauma center will activate the trauma team upon notification of the transporting agency or dispatcher. All designated trauma centers will activate their trauma team per WAC 246-976-870.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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B) REGION SPECIFIC PATIENT CARE PROCEDURES: ADAPT CLINIC AND URGENT CARE CLINIC TRANSPORTATION POLICY

Effective Date: 2009

1. PURPOSE: To provide guidance about patient transport to urgent care clinics.

2. **SCOPE**: This procedure applies to prehospital personnel.

3. **GENERAL PROCEDURES:**
Selected patients may be transported to a clinic, urgent care clinic, free standing emergency department, or hospital based emergency department via BLS transport if the patient meets the criteria listed below. These policies apply to non-primary (private) BLS ambulance when EMS personnel request private BLS ambulance to transport the patient.

1) The fire department based (primary) EMT provider considers a taxi to be an appropriate and safe method of transportation for the particular clinical problem.
2) Paramedic care is NOT required
3) Patient is ambulatory
4) Patient has a non-urgent condition (clinically stable) including
   a) Low index of suspicion for:
      a. Cardiac problem
      b. Stroke
      c. Abdominal aortic aneurysm
      d. GI bleed problems
   b) Low index of suspicion for major mechanism of injury
5) Patient must not have
   a) Need for a backboard
b) Uncontrolled bleeding
c) Uncontrolled pain
d) Need for oxygen (except patient self administered oxygen)
6) Patient should be masked if there are respiratory symptoms

For guidance regarding transport decisions EMTs may consult with paramedics or with emergency department personnel at the medical control hospital.
The EMT must notify the destination facility of the clinical problem and the facility must agree to accept the patient.

ADAPT Taxi Voucher Transportation Policy

Selected patients may be transported to a clinic, urgent care clinic, free standing emergency department, or hospital based emergency department via taxi if the following conditions listed above are met and the fire department-based EMT considers a taxi to be an appropriate and safe method of transportation for the particular clinical problem.

4. **APPENDICES:**

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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C) Region Specific Patient Care Procedures: Paramedic Training and Changes in Service Levels

Effective Date: 2009

1. PURPOSE: To provide information about paramedic training and service levels in the region.

2. **SCOPE**: Applies to prehospital agencies and leadership.

3. **GENERAL PROCEDURES:**
In order to maintain the highest quality care for prehospital emergencies it shall be required that:

1. The standard level response of ALS service shall be two paramedics. Exceptions may be authorized by the King County MPD for outlying districts and when split crews are required to respond to mass casualties.
2. King County paramedics shall be trained through and satisfy the educational requirements of the Paramedic Training program at the University of Washington/Harborview Medical Center.
3. Requests to expand or reduce service to a trauma response area, to change the level of EMS service provided, and new applications for EMS agencies seeking trauma verification must be reviewed and receive a recommendation by the Regional EMS Council in accordance with WAC 246-976-395(4).

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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			☐ Major ☐ Minor

DOH GUIDANCE DOCUMENTS

State of Washington
Prehospital Trauma Triage (Destination) Procedure

Purpose

The Trauma Triage Procedure was developed by the Centers for Disease Control in partnership with the American College of Surgeons, Committee on Trauma. The guidelines have been adopted by the Department of Health (DOH) based on the recommendation of the State EMS and Trauma Steering Committee.

The procedure is described in the attached algorithm. The guidelines represent the current best practice for the triage of trauma patients. The algorithm allows EMS and Trauma Responders to quickly and accurately determine if the patient is a major trauma patient. Major trauma patients must be taken to the highest appropriate level trauma facility in the defined system within 30 minutes transport time (Air or Ground).

The "defined system" is the trauma system that exists within an EMS and Trauma Care Region.

Explanation of Procedure

Any certified EMS and Trauma responder can identify a major trauma patient and activate the trauma system. This may include asking for Advanced Life Support response or air medical evacuation.

Step (1) Assess the patient's vital signs and level of consciousness using the Glasgow Coma Scale. Step 1 findings require activation of the trauma system. They also require rapid transport to the highest, most appropriate trauma center within 30 minutes transport time (ground or air). If unable to manage the patient's airway, consider meeting up with an ALS unit or transporting to the nearest facility capable of definitive airway management.

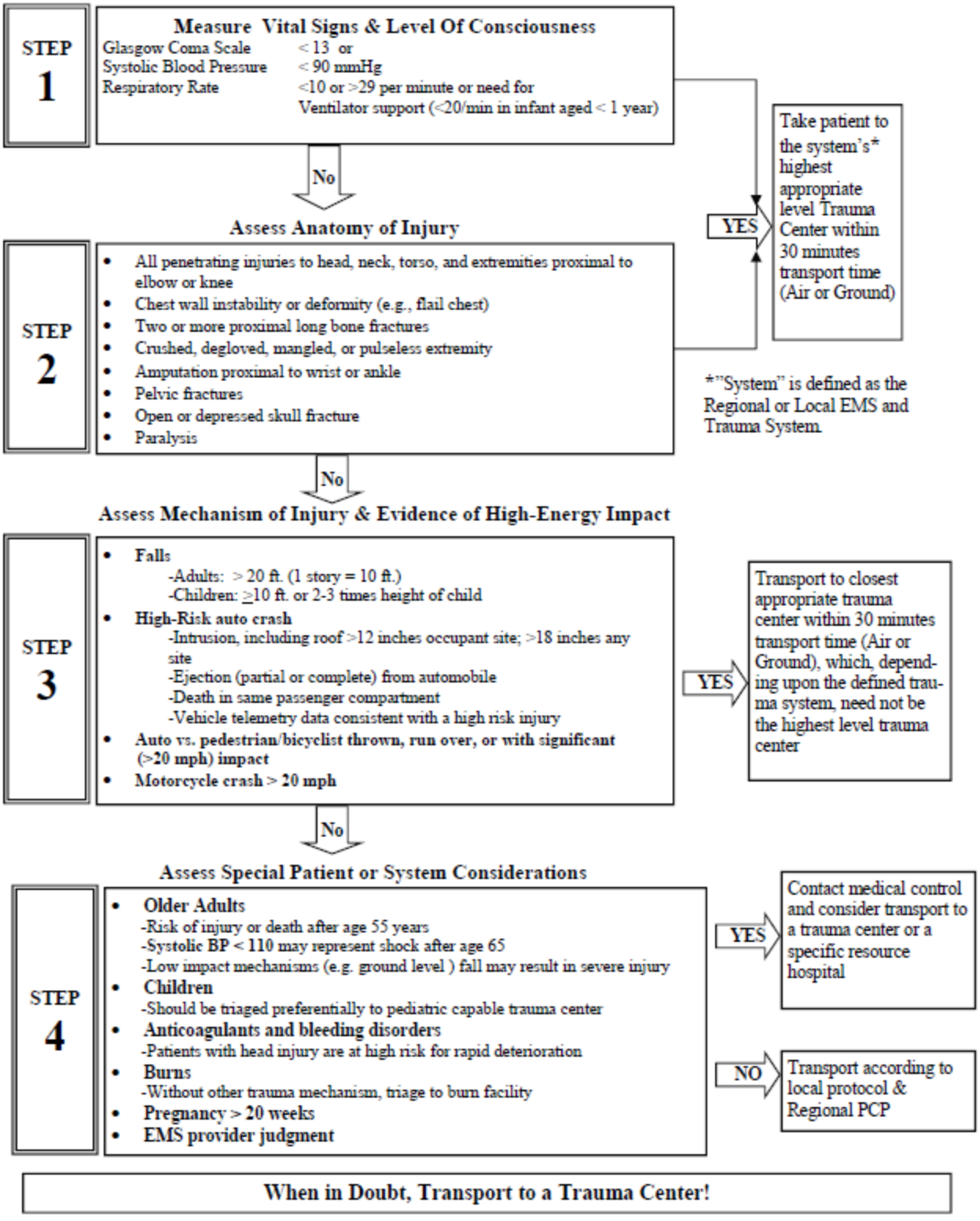
Step (2) Assess the anatomy of injury. Step 2 findings require activation of the trauma system. They also require rapid transport to the highest, most appropriate trauma center within 30 minutes transport time (ground or air). The presence of the specific anatomical injuries even with normal vital signs, lack of pain or normal levels of consciousness still require calling medical control and activating the trauma system.

Step (3) Assess biomechanics of the injury and address other risk factors. The conditions identified are reasons for the provider to transport to a trauma center. The destination trauma center need not be the highest level trauma center. Medical control should be contacted as soon as possible.

Step (4) has been added to assess special patients or system considerations. Risk factors coupled with "Provider Judgment" are reasons for the provider to contact Medical Control and discuss appropriate transport for these patients. In some cases, the decision may be to transport to the nearest trauma center.

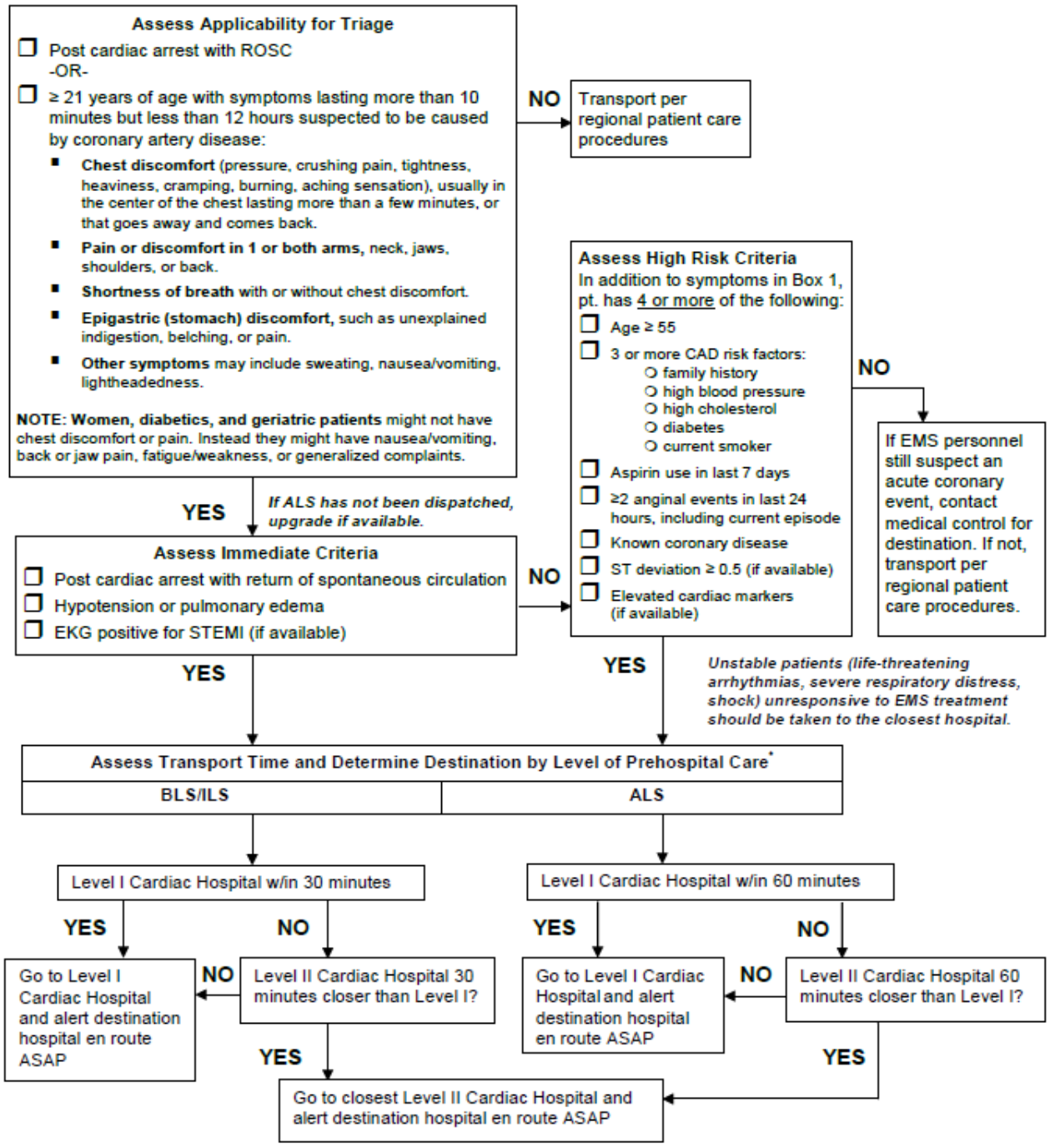
Regional Patient Care Procedures (PCP's) and Local County Operating Procedures (COPS) provide additional detail about the appropriate hospital destination. PCP's and COP's are intended to further define how the system operates. The Prehospital Trauma Triage procedure and the Regional Patient Care Procedures work in a "hand in glove" fashion to address trauma patient care needs.

Washington State Trauma Triage Destination Procedures



When in Doubt, Transport to a Trauma Center!

State of Washington
Prehospital Cardiac Triage Destination Procedure



* **Slight modifications to the transport times may be made in county operating procedures. See page 2.**
Consider ALS and air transport for all transports greater than 30 minutes.
If there are two or more Level I facilities to choose from within the transport timeframe, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in determining destination. This also applies if there are two or more Level II facilities to choose from.

DOH 346-050 April 2011

State of Washington
Prehospital Cardiac Triage Destination Procedure

Why triage cardiac patients?

The faster a patient having a heart attack or who's been resuscitated gets treatment, the less likely he or she will die or be permanently disabled. Patients with unstable angina and non-ST elevation acute coronary syndromes (UA/NSTE) are included in the triage procedure because they often need immediate specialized cardiac care. This triage procedure is intended to be part of a coordinated regional system of care that includes dispatch, EMS, and both Level I and Level II Cardiac Hospitals.

How do I use the Cardiac Triage Destination Procedure?

A. **Assess applicability for triage** – If a patient is post cardiac arrest with ROSC, or is over 21 and has any of the symptoms listed, the triage tool is applicable to the patient. Go to the "Assess Immediate Criteria" box. **NOTE**: Women, diabetics, and geriatric patients often have symptoms other than chest pain/discomfort so review all symptoms with the patient.

B. **Assess immediate criteria** – If the patient meets any one of these criteria, he or she is very likely experiencing a heart attack or other heart emergency needing immediate specialized cardiac care. Go to "Assess Transport Time and Determine Destination" box. If the patient does not meet immediate criteria, or you can't do an ECG, go to the "Assess High Risk Criteria" box.

C. **Assess high risk criteria** – If, in addition to meeting criteria in box 1, the patient meets four or more of these high risk criteria, he or she is considered high risk for a heart attack or other heart emergency needing immediate specialized cardiac care. These criteria are based on the TIMI risk assessment for unstable angina/non-STEMI. If the patient does not meet the high risk criteria in this box, but you believe the patient is having an acute coronary event based on presentation and history, consult with medical control to determine appropriate destination. High risk criteria definitions:

- ❒ 3 or more CAD (coronary artery disease) risk factors:
  - Age ≥ 55: epidemiological data for WA show that incidence of heart attack increases at this age
  - Family history: father or brother with heart disease before 55, or mother or sister before 65
  - High blood pressure: ≥140/90, or patient/family report, or patient on blood pressure medication
  - High cholesterol: patient/family report or patient on cholesterol medication
  - Diabetes: patient/family report
  - Current smoker: patient/family report.
- ❒ Aspirin use in last 7 days: any aspirin use in last 7 days.
- ❒ ≥2 anginal events in last 24 hours: 2 or more episodes of symptoms described in box 1 of the triage tool, including the current event.
- ❒ Known coronary disease: history of angina, heart attack, cardiac arrest, congestive heart failure, balloon angioplasty, stent, or bypass surgery.
- ❒ ST deviation ≥ 0.5 mm (if available): ST depression ≥ 0.5 mm is significant; transient ST elevation ≥ 0.5 mm for < 20 minutes is treated as ST-segment depression and is high risk; ST elevation >1 mm for more than 20 minutes places these patients in the STEMI treatment category.
- ❒ Elevated cardiac markers (if available): CK-MB or Troponin I in the "high probability" range of the device used. Only definitely positive results should be used in triage decisions.

D. **Determine destination** – The general guideline is to take a patient meeting the triage criteria directly to a Level I Cardiac Hospital within reasonable transport times. For BLS, this is generally within 30 minutes transport time, and for ALS, generally 60 minutes transport time. See below for further guidance. Regional patient care procedures and county operating procedures may provide additional guidance.

E. **Inform the hospital en route so staff can activate the cath lab and call in staff if necessary.**

What if a Level I Cardiac Hospital is just a little farther down the road than a Level II?

You can make slight changes to the 30/60 minute timeframe. The benefits of opening an artery faster at a Level I can outweigh the extra transport time. To determine whether to transport beyond the 30 or 60 minutes, figure the difference in transport time between the Level I Cardiac Hospital and the Level II Cardiac Hospital. For BLS, if the difference is more than 30 minutes, go to the Level II Cardiac Hospital. For ALS, if the difference is more than 60 minutes, go to the level II Cardiac Hospital.

BLS examples: A) minutes to Level I minus minutes to Level II = 29: go to Level I
B) Minutes to Level I minus minutes to Level II = 35: go to Level II

ALS examples: A) minutes to Level I minus minutes to Level II = 45: go to Level I
B) Minutes to Level I minus minutes to Level II = 68: go to Level II

NOTE: We recommend ALS use a fibrinolytic checklist to determine if a patient is ineligible for fibrinolysis. If ineligible, transport to closest Level I hospital even if it's greater than 60 minutes or rendezvous with air transport.

What if there are two or more Level I or II facilities to choose from?

If there are two or more of the same level facilities to choose from within the transport times, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in destination decision.

DOH 346-050 April 2011

Washington State Department of Health

State of Washington
Prehospital Stroke Triage Destination Procedure

STEP 1: Assess Likelihood of Stroke

- Numbness or weakness of the face, arm, or leg, especially on one side of the body
- Confusion, trouble speaking, or understanding
- Trouble seeing in one or both eyes
- Trouble walking, dizziness, loss of balance, or coordination
- Severe headache with no known cause

If any of above, proceed to STEP 2, if none, transport per regional PCP/county operating procedures

STEP 2: Perform F.A.S.T. Assessment (positive if any of Face/Arms/Speech abnormal)

- **Face:** Unilateral facial droop
- **Arms:** Unilateral arm drift or weakness
- **Speech:** Abnormal or slurred
- **Time:** Best estimate of Time Last Known Well =_____

If FAST negative, transport per regional/county operating procedures

STEP 3: If F.A.S.T. Positive - Calculate Stroke Severity Score (LAMS)

Facial Droop:	Absent 0	Present	1		
Arm Drift:	Absent 0	Drifts	1	Falls Rapidly	2
Grip Strength:	Normal 0	Weak	1	No Grip	2

Total Stroke Severity Score = **(max. 5 points)**

STEP 4: Determine Destination: Time Last Known Well + Stroke Severity Score

Time Last Known Well ≤ 6 Hours (Provide stroke alert to destination hospital ASAP)

OR

Time Last Known Well is > 6 Hours (regardless of Stroke Severity Score, alert destination hospital)

↓

Stroke Severity Score 4 or more?

NO → **Transport to nearest Level I or any Level II Stroke Center provided transport time is no more than 15 minutes greater than to a nearer Level III Stroke Center.**

YES ↓

Transport to nearest Level I or II Stroke Center with endo-vascular capability provided transport time is no more than 15 minutes greater than to a nearer Level II or Level III Stroke Center.

Additional Destination Considerations:

- ☐ Any additional transport time should not take the patient outside of the IV tPA time window.
- ☐ Assess availability of critical care air transport if it can help get the patient to a Stroke Center within the window of time for intervention.
- ☐ If unable to manage airway, consider rendezvous with ALS or intermediate stop at nearest facility capable of definitive airway management.
- ☐ If there are two or more Stroke Centers of the same level to choose from within the transport timeframe, patient preference, physician practice patterns, and local rotation agreements may be considered.

DOH 530-182 October 2017

Washington State Department of Health
Guideline for Implementing SHB 1721
July 2016

Background

In 2015 the Washington State Legislature passed legislation (SHB 1721) allowing emergency medical services ambulance and aid services to transport patients from the field to mental health or chemical dependency services. Participation is voluntary.

The Legislation

SHB 1721 section one calls for the Department of Health (department) in consultation, with the Department of Social and Health Services, to convene a workgroup comprising members of the steering committee and representatives of ambulance services, firefighters, mental health providers, and chemical dependency treatment programs. The workgroup was to establish alternative facility guidelines for developing protocols, procedures, and applicable training appropriate to the level of emergency medical service provider.

The guidelines shall consider when to transport to a mental health facility or chemical dependency treatment program to include:

- The presence of a medical emergency that requires immediate medical care;
- The severity of the mental health or substance use disorder needs of the patient;
- The training of emergency medical service personnel to respond to a patient experiencing emergency mental health or substance abuse disorders; and
- The risk the patient presents to the patient's self, the public, and the emergency medical service personnel.

By July 1, 2016, the department shall make the guidelines available to all regional emergency medical services and trauma care councils for incorporation into the patient care procedures of regional emergency medical services and trauma care plans.

Please forward questions about this document to:

Department of Health
Office of Community Health Systems
EMS and Trauma Section
P.O. Box 47853
Olympia, WA 98504
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HSQA.EMS@doh.wa.gov

Washington State Department of Health

What this means for regional EMS and trauma care councils
Regional EMS and trauma care councils shall develop a patient care procedure (PCP) that provides guidance to medical program directors and EMS agencies to operationalize transport of patients to a mental health or chemical dependency treatment facility. The PCP must:

- Direct participating facilities and agencies to adhere to the Washington State Department of Health Guideline for the Implementing SHB 1721 (guideline);
- Identify health care representatives and interested parties to be included in collaborative workgroups for designing and monitoring programs;
- Direct facilities that participate in the program to work with the medical program director (MPD) and EMS entities to reach consensus on criteria that all facilities and EMS entities participating in the program will follow for accepting patients.
- Include a statement that the facility participation is voluntary;
- Direct the local EMS council and MPD to establish a quality assurance process to monitor programs;
- Direct the local EMS council and MPD to develop and establish a county operating procedure (COP) inclusive of the standards recommended by the guideline and PCP, to include dispatch criteria, response parameters and other local nuances to operationalize the program;
- Direct the EMS MPD to establish a patient care protocol (protocol) inclusive of the standards and screening criteria recommended by the guideline and PCP;
- Direct the MPD to develop and implement department-approved education for emergency medical service personnel in accordance with the training requirements of the guideline. Educational programs must be approved by the department.

What this means for Local EMS and Trauma Care Councils
Local EMS and trauma care councils must collaborate with the MPD to develop a COP inclusive of the standards in the guideline. The COP must be consistent with state standards and the PCP.

The COP must include:

- A list of approved mental health and chemical dependency facilities participating in the program;
- Destination determination criteria including considerations for transports that may take the EMS service out of its county of origin;
- A list of options for methods of transport and any pertinent timelines for transport to occur;
- Guidance to EMS providers on when to contact law enforcement, and any procedures that must be considered during EMS and law enforcement interactions;
- Guidance to EMS providers on when to contact the designated mental health professional (DMHP) and any procedures to be considered during an involuntary hold.

What this means for medical program directors
MPDs must develop a patient care protocol inclusive of the standards and screening criteria in the guideline and PCP. The protocol must be consistent with state standards, PCP, and COP. The protocol should assist EMS providers in:

- Determining medical emergency that requires immediate care;
- Assessing the risk the patient presents to the patient's self, the public, and the emergency medical service personnel;
- Determining the severity of mental health or substance use disorder.

MPDs must develop and implement department-approved education for emergency medical service personnel who will respond and transport patients to mental health and chemical dependency facilities. Training must include content that meets the outlined criteria in **Appendix C** of this document.

Washington State Department of Health

Appendix A

EMS Screening Criteria for Transport to Mental Health Services

Inclusion criteria:

Facility:

Reference:

RCW 71.05.020 - Definitions
RCW 71.05.153 - Emergent detention of persons with mental disorders – Procedure

Mental health services authorized to receive patients include; crisis stabilization units, evaluation and treatment facilities and triage facilities.

Mental health services who have elected to operate as an involuntary facility may receive patients referred by a peace officer or a patient in involuntary status by a DMHP.

Patient:

- Voluntary with a mental health chief complaint willing to go to an alternative destination.
- Patients with a mental health chief complaint referred by a peace officer.
- Patients with a mental health chief complaint detained under the Involuntary Treatment Act (ITA) by a DMHP. The proper documents must be completed and signed by a DMHP for reimbursement.
- Patients with mental health complaints must have a clear history of mental health problems. No new onset mental health problems.
- The patient's current condition cannot be explained by another medical issue and traumatic injury is not suspected.
- The EMS agency was dispatched via 911.
- Age 18-55 is recommended based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and non-combative.
- Normal level of consciousness, no medical issues suspected.
- Suicidal patients may accept voluntary care, or may be detained by a peace officer or DMHP.
- HR 50-110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- BP systolic 100-190, diastolic less than 110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.

- RR 12-24 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Temperature 97-100.3 F is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Room air O2 saturation greater than 92 percent is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- If indicated check blood sugar, 70-300 is acceptable and is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Patient has the ability to care for self. MPDs may consider listing other criteria such as activities of daily living (ADLs).

Exclusion criteria:

Facility:

- Lack of bed availability
- Intake staff identifies concerns that exceed the ability of the facility to provide adequate care to the patient that requires local hospital emergency department -physician evaluation.
- Facilities may test for alcohol level and establish a cutoff level for acceptance that should not be below 300.

Patient:

- Intentional or accidental overdose
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy
- Anticoagulation. MPDs may specify medications in protocols to consideration.
- Blood sugar out of control over last 24 hours by patient history. MPDs may indicate a specific range or other language to clarify.
- Indwelling tubes, lines or catheters currently being utilized that the patient cannot manage.
- New onset of mental health problems. Mental health problem is not clearly indicated in patient history.
- MPDs and participating facilities must collaborate and determine triage criteria for people with functional and access needs, including developmental delay, traumatic brain injury, organic brain syndrome, dementia, etc.
- Any evidence for acute medical or traumatic problem.

Procedure:

- Scene safety and crisis de-escalation.
- Consider contacting law enforcement to assist EMS with on-scene mitigation of suicidal patients who are not voluntary, and for agitated or combative patients.
- Ask the patients if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and illicit drug use.
- Assess for inclusion and exclusion criteria.
- For patients who meet screening criteria, contact receiving center to determine resource availability. MPDs should consider identifying and including a list of available secondary resources other than the emergency room that can be used if a primary resource is unavailable.
- Contact medical control for approval.
- Secure a safe method of transportation identified and approved by the MPD in COPs or protocols.
- Document all findings and inclusion/exclusion criteria for all person contacts on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency-specific standard operating procedures.
- At time of patient care transfer, the completed inclusion/exclusion checklist should be provided to the receiving facility.
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatch and the reason documented.

Washington State Department of Health

Appendix B

EMS Screening Guideline for Transport to Chemical Dependency Services

Inclusion criteria:

Facility:

RCW 70.96A chemical dependency centers, and treatment centers, include sobering centers, and acute and subacute detox centers.

- Facility is identified as a crisis stabilization unit, evaluation and treatment facility, or triage facility that provides chemical dependency treatment services and mental health services.

Patient:

- Voluntary patients with a chemical dependency chief complaint willing to go to an alternative destination.
- Patients with a chemical dependency chief complaint referred by a peace officer.
- Patients with a mental health and/or chemical dependency chief complaint detained under the Involuntary Treatment Act (ITA) by a designated chemical dependency specialist (DCDS). The proper documents must be completed and signed by a DCDS for reimbursement.
- The patient's current condition cannot be not explained by another medical issue.
- The EMS agency was dispatched via 911 or police request.
- Age 18-55 is recommended based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and non-combative.
- Normal level of consciousness, no medical issues suspected.
- HR 50-110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- BP systolic 100-190, diastolic less than 110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- RR 12-24 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Temperature 97-100.3 F is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Room air O2 saturation greater than 92 percent is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.

- If indicated check blood sugar, 70-300 is acceptable and is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Patient has the ability to care for self. MPDs may consider listing other criteria such as activities of daily living (ADLs).

Exclusion criteria:

Facility:

- Lack of bed availability.
- Intake staff identifies concerns that require local hospital emergency department - physician evaluation.
- Facilities may test for alcohol level and establish a cutoff level for acceptance that should not be below 300.

Patient:

- Intentional or accidental overdose.
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy.
- Anticoagulation. MPDs may specify medications in protocols to consideration.
- Blood sugar out of control over past 24 hours by patient history. MPDs may indicate a specific range or other language to clarify.
- Indwelling tubes, lines or catheters currently being used.
- MPDs and participating facilities must collaborate and determine triage criteria for people with functional and access needs, including developmental delay, traumatic brain injury, organic brain syndrome, dementia, etc.
- Any evidence for acute medical or traumatic problem.

Procedure:

- Scene safety and crisis de-escalation.
- Contact law enforcement for suicidal patients who are not voluntary, and for agitated or combative patients.
- Ask the patients if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and drug use.
- Assess for inclusion and exclusion criteria.

- For patients who meet screening criteria, contact receiving center for resource availability.
- Contact medical control for approval.
- Secure safe method of transportation.
- Document all findings and inclusion/exclusion criteria for all person contacts on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency-specific standard operating procedures.
- At time of patient care transfer, provide the completed inclusion-exclusion checklist to the receiving facility.
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatch and the reason documented.

Washington State Department of Health

Appendix C

Education: The following is the minimum suggested content for department-approved MPD specialized training that shall be provided to EMS providers participating in transport programs authorized by SHB 1721 legislation and operating within the parameters of the guideline. Education programs must be approved by the department. Education must be provided on initial implementation and in an ongoing manner. MPDs may add content to the minimum recommended standards.

I. Review of the Regulatory Framework
- A. SHB 1721 Legislation and Department of Health Guideline
- B. Regional Patient Care Procedure
- C. County Operating Procedure
- D. Patient Care Protocol

II. Define Terms
- A. Receiving centers
  1. Mental Health Centers
  2. Chemical Dependency Centers
- B. Mental Health Professionals
  1. Emergency Social Worker
  2. Designated Mental Health Professional (DMHP)
- C. Involuntary referral
  1. Peace Officer
  2. DMHP
  3. Detainment Laws
  4. Mandatory reporting

III. Behavioral Health Emergencies and Crisis Response
- A. Crisis Intervention
  1. Crisis recognition and assessment
  2. Securing physical safety
     a. Withdraw from contact until scene safe
     b. Contain situation
     c. Call for adequate help
     d. Call for Law Enforcement
  3. Mitigation
  4. Destination decision making/Implementing an action plan
- B. Principles of crisis intervention
  1. Simplicity
  2. Brevity
  3. Innovation
  4. Practicality
  5. Proximity

6. Immediacy
7. Expectancy

C. SAFER-R
1. Stabilize the Situation
2. Acknowledge that something distressing has occurred
3. Facilitate the person's understanding of the situation
4. Encourage the person to make an acceptable plan of action
5. Recovery is evident

D. History/Assessment Tools
1. SAMPLE
2. OPQRST
3. SEA-3
4. MSE

F. Recognition of Increasing Rage/Risk of Violence
1. Bulging neck veins
2. Reddened face
3. Gritted Teeth
4. Muscle tension around jaw
5. Threatening Gestures
6. Threatening Posture
7. Display of a weapon
8. Clenched Fists
9. Wild or staring eyes

G. Suicide
1. Risk factors
2. Overt and covert clues
3. SADPERSONS Suicide assessment scale
4. Steps to bring a suicidal person to safety
   a. Secure the environment
   b. Develop trust and rapport
   c. Engage in a thorough risk assessment
   d. Develop a greater understanding of the person and issues that led up to the current situation
   e. Explore alternatives to suicide
   f. Select the best option for available alternatives
   g. Develop an action plan
   h. Implement the action plan
   i. Refer to appropriate facility

H. Dementia and Delirium
1. Definitions
2. Distinctions
3. Effect and association with emergent medical disorders
   a. Trauma
   b. Infection